FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037507

Facility Name: Sherman West Court

Address: 1950 Larkin Avenue (Number) Elgin (City) 60123-5843 (Zip Code)

County: Kane

Telephone Number: (847) 742-7070 **Fax #** (847) 742-7248

IDPA ID Number: 363725580001

Date of Initial License for Current Owners: 02/18/91

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of any desk review or audit adjustments to our accountant's address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 05/01/2001 to 04/30/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser, LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	112	Skilled (SNF)	112	40,880	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	8	Sheltered Care (SC)	8	2,920	5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,341	15,821	9,431	29,593	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		3,302		3,302	12
13	DD 16 OR LESS					13
14	TOTALS	4,341	19,123	9,431	32,895	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.10%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Nonallowable expenses have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/18/91

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 02/18/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 34 and days of care provided 9,106

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 04/30/2002 Fiscal Year: 04/30/2002

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 **Report Period Beginning:** 05/01/2001 **Ending:** 04/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	230,774	11,569	4,188	246,531		246,531		246,531			1
2	Food Purchase		162,986		162,986		162,986	(2,799)	160,187			2
3	Housekeeping	107,200		17,454	124,654		124,654		124,654			3
4	Laundry	33,283	8,749		42,032		42,032		42,032			4
5	Heat and Other Utilities			110,886	110,886		110,886		110,886			5
6	Maintenance	86,610	3,230	54,808	144,648		144,648		144,648			6
7	Other (specify):*											7
8	**TOTAL General Services**	457,867	186,534	187,336	831,737		831,737	(2,799)	828,938			8
	B. Health Care and Programs											
9	Medical Director			42,300	42,300		42,300		42,300			9
10	Nursing and Medical Records	2,077,919	128,955	2,872	2,209,746		2,209,746		2,209,746			10
10a	Therapy	310,162	1,680	3,440	315,282		315,282		315,282			10a
11	Activities	64,239	2,343	3,051	69,633		69,633	537	70,170			11
12	Social Services	39,846			39,846		39,846		39,846			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,492,166	132,978	51,663	2,676,807		2,676,807	537	2,677,344			16
	C. General Administration											
17	Administrative	73,794		270,000	343,794		343,794	(270,000)	73,794			17
18	Directors Fees											18
19	Professional Services			75,154	75,154		75,154	(3,278)	71,876			19
20	Dues, Fees, Subscriptions & Promotions			27,501	27,501		27,501		27,501			20
21	Clerical & General Office Expenses	290,753	7,889	43,040	341,682		341,682	272,413	614,095			21
22	Employee Benefits & Payroll Taxes			643,763	643,763		643,763		643,763			22
23	Inservice Training & Education											23
24	Travel and Seminar			21,049	21,049		21,049		21,049			24
25	Other Admin. Staff Transportation			269	269		269		269			25
26	Insurance-Prop.Liab.Malpractice			67,013	67,013		67,013		67,013			26
27	Other (specify):*											27
28	**TOTAL General Administration**	364,547	7,889	1,147,789	1,520,225		1,520,225	(865)	1,519,360			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,314,580	327,401	1,386,788	5,028,769		5,028,769	(3,127)	5,025,642			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sherman West Court #0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			221,433	221,433		221,433	14,382	235,815			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			236,979	236,979		236,979	(6,260)	230,719			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,108	9,108		9,108		9,108			35
36	Other (specify):*											36
37	**TOTAL Ownership**			467,520	467,520		467,520	8,122	475,642			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			7,116	7,116		7,116		7,116			38
39	Ancillary Service Centers		463,034		463,034		463,034		463,034			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,320	61,320		61,320		61,320			42
43	Other (specify):* Nonallowable Costs			59,885	59,885		59,885	(59,885)				43
44	**TOTAL Special Cost Centers**		463,034	128,321	591,355		591,355	(59,885)	531,470			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,314,580	790,435	1,982,629	6,087,644		6,087,644	(54,890)	6,032,754			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,735)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,913)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	676	30		9
10	Interest and Other Investment Income	(6,260)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,380)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,461)	43		24
25	Fund Raising, Advertising and Promotional	(16,079)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,612)	21		28
29	Other-Attach Schedule See attached Schedule 5A	(14,894)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (81,658)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	26,768		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 26,768		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (54,890)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court
IDPH Facility ID # 0037507
4/30/2002

Schedule 5A

Schedule VI.
Line 29, Other

Nonallowable Expenses	Amount	Reference
Printing and forms	(3,428)	43
Lab expense	(6,537)	43
Income offset	(1,124)	21
Activity income offset	537	11
Out of period legal fees	(3,278)	19
Vending income offset	(1,064)	2
Total	(14,894)	

See Accountants' Compilation Report

Sherman West Court

ID# 0037507

Report Period Beginning: 05/01/2001

Ending: 04/30/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sherman West Court # 0037507 **Report Period Beginning:** 05/01/2001 **Ending:** 04/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,735)	0	0	0	0	0	0	0	0	0	0	(1,735)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,735)	0	0	0	0	0	0	0	0	0	0	(1,735)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(270,000)	0	0	0	0	0	0	0	0	0	(270,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(9,525)	283,062	0	0	0	0	0	0	0	0	0	273,537	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(9,525)	13,062	0	0	0	0	0	0	0	0	0	3,537	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,260)	13,062	0	0	0	0	0	0	0	0	0	1,802	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sherman West Court # 0037507 **Report Period Beginning:** 05/01/2001 **Ending:** 04/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	676	13,706	0	0	0	0	0	0	0	0	0	14,382	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,260)	0	0	0	0	0	0	0	0	0	0	(6,260)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(5,584)	13,706	0	0	0	0	0	0	0	0	0	8,122	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(49,920)	0	0	0	0	0	0	0	0	0	0	(49,920)	43
44	**TOTAL Special Cost Centers**	(49,920)	0	0	0	0	0	0	0	0	0	0	(49,920)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(66,764)	26,768	0	0	0	0	0	0	0	0	0	(39,996)	45

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sherman Health Systems	100%			Sherman Hospital	Elgin	Hospital
				Sherman Home		Home Health
				Care Partners	Elgin	Agency
				Sherman Health		
				Systems	Elgin	Management Co.
See Schedule 6A for Board of Directors						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 270,000	Sherman Health Systems	100.00%	$	$ (270,000)	1
2	V	21	Administrative Expenses		Sherman Health Systems	100.00%	283,062	283,062	2
3	V	30	Depreciation Expense		Sherman Health Systems	100.00%	13,706	13,706	3
4	V	10	Nursing Cost	13,738	Sherman Hospital		13,738		4
5	V	21	Office Supplies	(1,217)	Sherman Hospital		(1,217)		5
6	V	22	Fringe Benefits	47,544	Sherman Hospital		47,544		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 330,065			$ 356,833	$ * 26,768	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court
Facility #0037507
04/30/2002

Medicaid Cost Report
Schedule 6A

Page 6: VII - Schedule A - Non-Profit required attachment: List of Board of Directors

Board Member	Directly Provided Services	Type of Service	Entity owned by Board Member doing Business with nursing home	Type of Business Conducted
Reverend Dr. Robert D. Linstrom	No	N/A	N/A	N/A
Richard S.Scheflow	No	N/A	N/A	N/A
Earl W. Lamp	No	N/A	N/A	N/A
Al Pagorski	No	N/A	N/A	N/A
Toni Geister	No	N/A	N/A	N/A
Richard Floyd	No	N/A	N/A	N/A
Kyung W. Koo, M.D.	Yes	Medicare Medical Director	N/A	N/A
Elaine Hastings	No	N/A	N/A	N/A
D. Ray Wilson	No	N/A	N/A	N/A

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3				N/A							3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 4/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sherman Health Systems
Street Address: 1019 East Chicago Street
City / State / Zip Code: Elgin, IL 60120-6822
Phone Number: (847) 608-6114
Fax Number: (847) 608-6117

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Administrative Expenses	Accumulated Costs	185,659,737	3	$ 8,678,879	$	6,055,294	$ 283,062	1
2	30	Depreciation Expense	Accumulated Costs	185,659,737	3	420,229		6,055,294	13,706	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,099,108	$		$ 296,768	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Illinois Health Facilities		x	Refinance construction bond	$24,326.00	10/15/97	$ 4,736,121	$ 4,369,827	8/2027	Various	$ 236,979	1
2	Authority											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$24,326.00		$ 4,736,121	$ 4,369,827			$ 236,979	9
	B. Non-Facility Related*											
10	Interest Income Offset										(6,260)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (6,260)	14
15	TOTALS (line 9+line14)						$ 4,736,121	$ 4,369,827			$ 230,719	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ None** **Line # N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

No real estate taxes to be paid in 2001 or 2002 due to real estate tax exempt status being granted.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sherman West Court COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0037507

CONTACT PERSON REGARDING THIS REPORT Ms. Anne Huang

TELEPHONE (847) 742-7070 FAX #: (847) 742-7248

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,260 B. General Construction Type: Exterior Brick Frame Wood/Masonry Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	115,500	1991	$ 504,179	1
2					2
3	TOTALS	115,500		$ 504,179	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1991	1991	$ 2,486,860	$ 62,171	40	$ 62,171	$	$ 696,839	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1991	99,031		5			99,031	9
10	Building Improvements			1991	219,089	913	10	913		219,089	10
11	Building Improvements			1991	205,843	13,723	15	13,723		153,811	11
12	Building Improvements			1991	826,676	41,334	20	41,334		463,284	12
13	Building Improvements			1991	91,155	3,646	25	3,646		40,867	13
14	Building Improvements			1991	21,960	2,196	10	2,196		23,058	14
15	Building Improvements			1991	3,398	227	15	227		2,379	15
16	Building Improvements			1992	22,980	2,298	10	2,298		21,831	16
17	Building Improvements			1992	2,000	183	15	133	(50)	1,266	17
18	Building Improvements			1993	962		5			962	18
19	Building Improvements			1993	13,219	1,322	10	1,322		11,236	19
20	Building Improvements			1993	3,750	250	15	250		2,125	20
21	Building Improvements			1993	14,525		20	726	726	6,172	21
22	Building Improvements			1994	6,951	348	20	348		2,607	22
23	Carpet Tiles			1995	1,500	150	10	150		975	23
24	Sliding Doors			1996	3,345	334	10	334		2,174	24
25	Resurface Parking Lot			1996	4,800	480	5	480		4,800	25
26	Carpeting			1997	3,930	393	5	393		3,930	26
27	Carpet/tile Base			1997	12,580	1,474	5	1,474		12,580	27
28	Kickplates			1997	4,165	833	5	833		3,748	28
29	Carpet Living Room			1998	4,340	433	10	433		1,517	29
30	Cement Board & Ceramic Tile			1999	4,475	448	10	448		1,568	30
31	Wallpaper			1999	1,819	363	5	363		1,272	31
32	Landscaping			1999	893	179	5	179		626	32
33	Construction contract for new entrance & nursing statior			1999	938,914	23,473	40	23,473		67,978	33
34	Kitchen Wall Boards			2000	1,365	273	5	273		682	34
35	Parking Lot Improvements			2000	52,250	1,742	30	1,742		3,484	35
36	Purchasing Department Ceiling Light Fixtures			2000	1,967	197	10	197		394	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpeting	2002	$ 19,943	$ 166	5	$ 166	$	$ 166	37
38	Wallpaper	2002	19,893	166	5	166		166	38
39	Roofing	2001	1,400	70	10	70		70	39
40	Door	2001	1,125	38	15	38		38	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,097,103	$ 159,823		$ 160,499	$ 676	$ 1,850,725	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 668,941	$ 61,021	$ 61,021	$	5-20	$ 371,945	71
72	Current Year Purchases	53,967	589	589		5-15	589	72
73	Fully Depreciated Assets	417,502				5	417,502	73
74	Allocated from Sherman Health Systems			13,706	13,706			74
75	TOTALS	$ 1,140,410	$ 61,610	$ 75,316	$ 13,706		$ 790,036	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,741,692	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 221,433	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 235,815	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 14,382	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,640,761	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 9,108 Description: Copy Machines: $9,108
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [X] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10A, C 1 & 3	2866 hrs	$ 60,017	80	$ 3,440	$	2,946	$ 63,457	1
2	Licensed Speech and Language Development Therapist	L10A, C 1 & 2	911 hrs	24,498				911	24,498	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C 1 &2	9740 hrs	225,647			1,680	9,740	227,327	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C 2	# of prescrpts				428,370		428,370	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Specialized Beds Other (specify): Oxygen	L39, C 2 L39, C 2					8,463 26,201		26,201	13
14	TOTAL			$ 310,162	80	$ 3,440	$ 464,714	13,597	$ 769,853	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court
Provider #: 0037507
05/01/2001 to 04/30/2002

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
	L39, C3			
	L39, C3			
	L39, C3			
	L39, C3			
Total			0	0

See Accountants' Compilation Report

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 04/30/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 659,091	$ 659,091	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 119,683)	1,271,592	1,271,592	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,962	24,962	6
7	Other Prepaid Expenses	10,555	10,555	7
8	Accounts Receivable (owners or related parties)	92,846	92,846	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,059,046	$ 2,059,046	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	504,179	504,179	13
14	Buildings, at Historical Cost	5,083,338	5,097,103	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,141,280	1,140,410	16
17	Accumulated Depreciation (book methods)	(2,635,395)	(2,640,761)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Bond Issue Cost	82,563	82,563	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,175,965	$ 4,183,494	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,235,011	$ 6,242,540	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 143,947	$ 143,947	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	80,700	80,700	29
30	Accrued Salaries Payable	208,279	208,279	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	57,471	57,471	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Parties	2,908,855	2,908,855	36
37	Deferred Income, Accrued Expenses	257,052	257,052	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,656,304	$ 3,656,304	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,289,127	4,289,127	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,289,127	$ 4,289,127	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,945,431	$ 7,945,431	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,710,420)	$ (1,702,891)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,235,011	$ 6,242,540	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,844,225)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,844,225)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	133,805	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 133,805	17	
	B. Transfers (Itemize):			
18	**Endowment Fund**		18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,710,420)	24	*

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,706,817	1
2	Discounts and Allowances for all Levels	(1,183,432)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,523,385	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	745,409	6
7	Oxygen	82,544	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 827,953	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,812	13
14	Non-Patient Meals	1,735	14
15	Telephone, Television and Radio	5,913	15
16	Rental of Facility Space		16
17	Sale of Drugs	638,089	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,501	19
20	Radiology and X-Ray		20
21	Other Medical Services	201,266	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 859,316	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,260	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,260	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous, Vending, & Activities Income**	1,651	28
28a	**Endowment Income**	2,884	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,535	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,221,449	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	831,737	31
32	Health Care	2,676,807	32
33	General Administration	1,520,225	33
	B. Capital Expense		
34	Ownership	467,520	34
	C. Ancillary Expense		
35	Special Cost Centers	530,035	35
36	Provider Participation Fee	61,320	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,087,644	40
41	**Income before Income Taxes (line 30 minus line 40)****	133,805	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 133,805	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,291	4,998	$ 142,765	$ 28.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	31,007	37,437	939,677	25.10	3
4	Licensed Practical Nurses	8,212	8,980	156,120	17.39	4
5	Nurse Aides & Orderlies	56,000	59,760	773,529	12.94	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,931	6,079	174,343	28.68	7
8	Rehab/Therapy Aides	7,586	8,125	135,819	16.72	8
9	Activity Director	1,946	2,086	32,387	15.53	9
10	Activity Assistants	3,172	3,490	31,852	9.13	10
11	Social Service Workers	1,789	1,949	39,846	20.44	11
12	Dietician	465	465	9,688	20.83	12
13	Food Service Supervisor	1,654	1,782	37,773	21.20	13
14	Head Cook	7,931	8,243	93,242	11.31	14
15	Cook Helpers/Assistants					15
16	Dishwashers	11,217	11,423	90,071	7.89	16
17	Maintenance Workers	4,267	4,617	86,610	18.76	17
18	Housekeepers	12,521	13,890	107,200	7.72	18
19	Laundry	3,630	4,073	33,283	8.17	19
20	Administrator	1,870	2,086	73,794	35.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,870	2,086	55,332	26.53	23
24	Clerical	12,146	16,670	235,421	14.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,645	1,880	25,829	13.74	31
32	Other Health Ca See Sch. 20A	2,664	3,002	39,999	13.32	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	181,814	203,121	$ 3,314,580 *	$ 16.32	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	42,300	L 9, C 3	36
37	Medical Records Consultant	Quarterly	778	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,395	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	80	3,440	L 10A, C 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Quarterly	752	L 11, C 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	X-ray	Monthly	699	L 10, C 3	47
48					48
49	TOTAL (lines 35 - 48)	80	$ 49,364		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Sherman West Court
IDPH Facility ID # 0037507
4/30/2002

Schedule 20A

Schedule XVIII
Line 32, Other

Description	Hours Worked	Hours Paid	Salaries/ Wages	Average
MDS Coordinator	558	558	13,309	23.85
Nursing Secretary	2,106	2,444	26,690	10.92
Total	2,664	3,002	39,999	

See Accountants' Compilation Report

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anne Huang	Administrator	0%	$ 73,794
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,794

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 270,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 270,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Scheflow & Rydell	Legal	$ 1,482
Bell, Boyd, & Lloyd LLC	Legal	2,500
Hutton Nelson & McDonald LLP	Accounting	18,566
Altschuler, Melvion & Glasser LLP	Accounting	29,992
American Express Tax and Business Services Inc.	Consulting	15,512
Accu-Med Services	Computer Processing	7,102
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 75,154

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 111,164
Unemployment Compensation Insurance	20,550
FICA Taxes	253,234
Employee Health Insurance	143,190
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Contributions	44,747
Employee Recognition	4,231
Employee Benefits PTO	36,092
Other Employee Insurance	16,503
Other Employee Benefits	14,052
TOTAL (agree to Schedule V, line 22, col.8)	$ 643,763

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	18,878
Health Care Worker Background Check	
(Indicate # of checks performed)	
Life Services Network	4,370
Miscellaneous Dues & Subscriptions	3,568
Miscellaneous License, Permits	685
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,501

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	21,049
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 21,049

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court
Provider #: 0037507
05/01/2001 to 04/30/2002

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)		75,154
Allocated from Management Company		
Less:	**Out of period legal fees**	(3,278)
Total (agree to Schedule V, line 19, column 8)		71,876

See Accountants' Compilation Report

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/2001 Ending: 04/30/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $4,370**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **12.5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,853** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **61,320**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,735**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ernst & Young LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Sherman West Court** **04:16 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-54,890	equal to	-54,890	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	230,719	equal to	230,719	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	235,815	equal to	235,815	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	9,108	equal to	9,108	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	310,162	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	318,722	equal to	315,282	3,440	FAILED	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	464,714	equal to	464,714	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	831,737	equal to	831,737	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,676,807	equal to	2,676,807	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,520,225	equal to	1,520,225	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	467,520	equal to	467,520	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	530,035	equal to	530,035	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	61,320	equal to	61,320	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,037,920	equal to	2,077,919	-39,999	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	174,343	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	64,239	equal to	64,239	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	39,846	equal to	39,846	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	230,774	equal to	230,774	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	86,610	equal to	86,610	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	107,200	equal to	107,200	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	33,283	equal to	33,283	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	73,794	equal to	73,794	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	290,753	equal to	290,753	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,314,580	equal to	3,314,580	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	4,188	-4,188	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	42,300	< or = to	42,300	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	2,173	< or = to	2,872	-699	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	752	< or = to	3,051	-2,299	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	73,794	equal to	73,794	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	270,000	equal to	270,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	75,154	equal to	75,154	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	643,763	equal to	643,763	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	27,501	equal to	27,501	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	21,049	equal to	21,049	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	61,320	equal to	61,320	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	None	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	None	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	9,106	equal to	9,431	-325	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	26,768	equal to	26,768	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	4,369,827	equal to	4,369,827	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	504,179	equal to	504,179	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	5,097,103	equal to	5,097,103	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,140,410	equal to	1,140,410	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,640,761	equal to	2,640,761	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-1,710,420	equal to	-1,710,420	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	133,805	equal to	133,805	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	6,235,011	equal to	6,235,011	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	230,774	11,569	4,188	246,531	0	246,531	0	246,531
2. Food Purchase	0	162,986	0	162,986	0	162,986	-2,799	160,187
3. Housekeeping	107,200	0	17,454	124,654	0	124,654	0	124,654
4. Laundry	33,283	8,749	0	42,032	0	42,032	0	42,032
5. Heat and Other Utilities	0	0	110,886	110,886	0	110,886	0	110,886
6. Maintenance	86,610	3,230	54,808	144,648	0	144,648	0	144,648
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	457,867	186,534	187,336	831,737	0	831,737	-2,799	828,938
9. Medical Director	0	0	42,300	42,300	0	42,300	0	42,300
10. Nursing & Medical Records	2,077,919	128,955	2,872	2,209,746	0	2,209,746	0	2,209,746
10a. Therapy	310,162	1,680	3,440	315,282	0	315,282	0	315,282
11. Activities	64,239	2,343	3,051	69,633	0	69,633	537	70,170
12. Social Services	39,846	0	0	39,846	0	39,846	0	39,846
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,492,166	132,978	51,663	2,676,807	0	2,676,807	537	2,677,344
17. Administrative	73,794	0	270,000	343,794	0	343,794	-270,000	73,794
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	75,154	75,154	0	75,154	-3,278	71,876
20. Fees, Subscriptions & Promotion	0	0	27,501	27,501	0	27,501	0	27,501
21. Clerical & General Office	290,753	7,889	43,040	341,682	0	341,682	272,413	614,095
22. Employee Benefits & Payroll	0	0	643,763	643,763	0	643,763	0	643,763
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	21,049	21,049	0	21,049	0	21,049
25. Other Admin. Staff Trans	0	0	269	269	0	269	0	269
26. Insurance-Prop.Liab.Malpractice	0	0	67,013	67,013	0	67,013	0	67,013
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	364,547	7,889	1,147,789	1,520,225	0	1,520,225	-865	1,519,360
29. Total General Administrative	3,314,580	327,401	1,386,788	5,028,769	0	5,028,769	-3,127	5,025,642
30. Depreciation	0	0	221,433	221,433	0	221,433	14,382	235,815
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	236,979	236,979	0	236,979	-6,260	230,719
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	9,108	9,108	0	9,108	0	9,108
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	467,520	467,520	0	467,520	8,122	475,642
38. Medically Necessary T	0	0	7,116	7,116	0	7,116	0	7,116
39. Ancillary Service Cent	0	463,034	0	463,034	0	463,034	0	463,034
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	61,320	61,320	0	61,320	0	61,320
43. Other (specify):*	0	0	59,885	59,885	0	59,885	-59,885	0
44. Total Special Cost Ce	0	463,034	128,321	591,355	0	591,355	-59,885	531,470
45. Grand Total	3,314,580	790,435	1,982,629	6,087,644	0	6,087,644	-54,890	6,032,754

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	659,091	659,091
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,271,592	1,271,592
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	24,962	24,962
7. Other Prepaid Expenses	10,555	10,555
8. Accounts Receivable-Owner/Related Party	92,846	92,846
9. Other (specify):	0	0
10. Total current assets	2,059,046	2,059,046
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	504,179	504,179
14. Buildings, at Historical Cost	5,083,338	5,097,103
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	1,141,280	1,140,410
17. Accumulated Depreciation (book methods)	-2,635,395	-2,640,761
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	82,563	82,563
24. Total Long-Term Assets	4,175,965	4,183,494
25. Total Assets	6,235,011	6,242,540
CURRENT LIABILITIES		
26. Accounts Payable	143,947	143,947
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	80,700	80,700
30. Accrued Salaries Payable	208,279	208,279
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	57,471	57,471
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,908,855	2,908,855
37. Other Current Liabilities (specify):	257,052	257,052
38. Total Current Liabilities	3,656,302	3,656,302
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	4,289,127	4,289,127
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	4,289,127	4,289,127
46.Total Liabilities	7,945,429	7,945,429
47.Total Equity	-1,710,418	-1,702,889
48.Total Liabilities and Equity	6,235,011	6,242,540

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	5,706,817
2. Discounts and Allowances for all Levels	-1,183,432
Subtotal - Inpatient Care	4,523,385
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	745,409
7. Oxygen	82,544
Subtotal - Anciliary Revenue	827,953
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	2,812
14. Non-Patient Meals	1,735
15. Telephone, Television, and Radio	5,913
16. Rental of Facility Space	0
17. Sale of Drugs	638,089
18. Sale of Supplies to Non-Patients	0
19. Laboratory	9,501
20. Radiologyand X-Ray	0
21. Other Medical Services	201,266
22. Laundry	0
Subtotal - Other Operating Revenue	859,316
24. Contributions	0
25. Interest and Other Investments Income	6,260
Subtotal - Non-Operating Revenue	6,260
27. Other Revenue (specify):	1,651
28. Other Revenue (specify):	2,884
Subtotal - Other Revenue	4,535
30. Total Revenue	6,221,449
31. General Services	831,737
32. Health Care	2,676,807
33. General Administration	1,520,225
34. Ownership	467,520
35. Special Cost Centers	530,035
35. Provider Participation Fee	61,320
37. Other	0
40. Total Expenses	6,087,644
41. Income Before Income Taxes	133,805
42. Income Taxes	0
43. Net Income or Loss for the Year	133,805